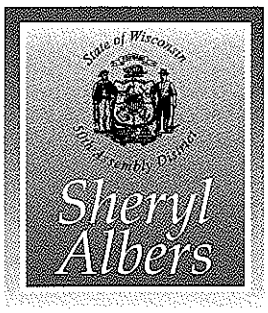

State Representative Albers Testimony on SB 375 to
The Senate Committee on Health, Human Services, Insurance,
& Job Creation – January 17, 2008

Thank you Chairman Erpenbach and members for your consideration today of Senate Bill 375, the Mental Health Fairness Act. This legislation has been introduced in some form over the last ten years, and in that time as lawmakers we have heard personal stories of how mental illness has impacted an individual or family in heart-wrenching ways, about discrimination in insurance coverage, advancements in diagnosing and treating mental illnesses, and whether or not equal coverage of mental illnesses will result in higher costs for other consumers and businesses in the insurance market. Today, however, I want to focus on how passage of SB 375 can also improve worker productivity and Wisconsin's business climate.

SB 375 requires all insurers to provide coverage for mental health services, equal to that provided for physical health care.

Ensuring equal treatment of both types of health care makes sense for Wisconsin's economy:

- Various studies have shown that U.S. businesses lose between $79 and $105 billion per year due to inadequately treated mental illnesses.

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- 36 million productive workdays are lost every year in the U.S. due to behavioral health disorders, costing employers an estimated $5 billion annually.
- In fact, the National Committee for Quality Assurance estimated that nationally there were 8.4 million sick and lost productivity days among workers with depression alone, amounting to almost $1.4 billion in lost productivity. In Wisconsin, the number of work days lost to depression alone is 170,000 days/yr. More days are lost when other mental health disorders are added to the mix.
- Wisconsin employers lose roughly 226,000 days per year in reduced worker productivity due to depression-related illness.
- Research also suggests that workers with inadequate coverage who have a mental illness or substance abuse often rely upon short-term disability benefits.
- Studies show that workers not undergoing treatment for a mental health disorder are more likely to be indecisive, make poor judgments, and lack self-confidence, which frequently results in accidents in the workplace, and increased draws on unemployment compensation or workers comp accounts.

Comparable treatment of mental health services can reverse these sobering numbers, benefiting employers and employees, without significant cost to insured/payers. If enacted, Wisconsin businesses would save millions of

dollars every year in recovered work days, worker productivity, reduced number of disability claims and lowered training and recruitment costs. Our business climate here would improve as Wisconsin would join the 41 other states which have already enacted mental health parity legislation, giving business owners another reason to consider Wisconsin's workforce when contemplating startups or expansions.

It is expected that Wisconsin's federal UC account will fall into negative balance if UC criteria are not modified this session. Not all states which have had mental health parity in place for several years face like circumstances as to their UC accounts. There may be a direct correlation, and there are several studies which suggest Wisconsin's UC account would experience less draws if a mental health parity law were enacted here.

This bill has been misrepresented by many as simply another unfunded health mandate. Studies of states which have already enacted mental health parity show that full coverage of mental illness and substance abuse results in significant health care savings throughout the insurance market within the first three to five years. Some states with sound managed care systems experienced net savings within the first two years of implementation. Proper treatment of mental illness has been found to reduce the number of claims for physical health services, ultimately resulting in lower premiums or slower premium growth for all persons in the insurance pool.

In closing, I would invite committee members who disagree with the proposal before them to look at parity laws in other states and work with us on a solution that does not leave consumers, businesses and taxpayers behind here in Wisconsin.

Sen. Hansen

SB 375—1.17.08 Testimony

Thank you, Chairman Erpenbach and committee members, for holding a public hearing today on Senate Bill 375. The weather could have been more cooperative, but we're used to that around here.

Senate Bill 375 is the latest in a long line of mental health insurance proposals that have been brought before the Senate. As many of you know, a very similar bill passed the state Senate in 2001. Since that time, unfortunately, it has never received an up or down vote in the state Senate or Assembly. We're hoping to change that this year, and I'm cautiously optimistic about our chances.

Support for the proposal has never been stronger. The coalition in support of the bill is broad and deep. And the data supportive of the cause has never been more persuasive.

Subsequent speakers will address many of these issues. They will touch on the affordability of the requirement, how business competitiveness can be positively impacted by the legislation and how worker productivity can be improved when mental health care is accessible. These facts and figures are important to keep in mind when opponents raise concerns with the legislation's impact on the business climate, but I will leave these points to the experts.

I want to just briefly explain my position on this legislation, why I am proud to author the bill and why this bill is so important from a moral and ethical perspective.

Earlier this year, I had the pleasure of attending my son-in-law's graduation from the College of Podiatric Medicine and Surgery at Des Moines University. The commencement address was delivered by former Arkansas Governor Mike Huckabee, a Republican presidential candidate and the winner of the Iowa caucuses. I was prepared for a run-of-the-mill partisan stump speech, but instead was treated to something very different by a preacher-politician who knows a thing or two about public speaking.

That day, Mr. Huckabee spoke of a young soldier who returned from Iraq with lasting psychological and emotional scars. The soldier recognized that he was in trouble and tried to get help at the local VA, but he was told to come back another day. Tragically, this young man didn't have another day. He went home and took his own life.

Huckabee passionately delivered this story, and used it as an opportunity to call for better mental health treatment for our returning soldiers who have suffered through the horrors of the Iraq War.

I wholeheartedly agree with his call, and have voted to increase funding for the state's Veterans Assistance Program, but I also recognize the problem extends far beyond the brave veterans who battle mental illness. People across this state and nation, people who have never seen a battlefield are dealing with mental illnesses that are just as real and debilitating as those faced by our men and women in uniform.

In fact, according to the Wisconsin Department of Health and Family Services, about 629 suicide deaths occur in Wisconsin, and an average of 4,944 suicide related hospitalizations take place each

year. Many of these deaths are highly preventable and could be prevented if all sufferers of mental illness had access to the prevention services they deserve.

To put it simply, current laws that allow for the inequitable treatment of mental health and substance abuse disorders are nothing more than legalized discrimination. Mental illnesses are medical problems—not character flaws—and should be treated as such.

The time has come to stand up to powerful special interests that stand in the way of progress at every turn. I plan to continue just that, and I hope that Assembly leadership will finally join me in this effort.

I'll now close with the words of one of my favorite public servants, the late Sen. Paul Wellstone, a terrific statesman and the man after whom federal mental health parity legislation is now named. He said, "Politics isn't about big money or power games; it's about the improvement of people's lives."

I hope you'll all join me in working to create this kind of politics—the kind of politics of which we can all be proud—by working to improve the lives of Wisconsinites who continue to struggle with the stigma of mental illness.

Thank you.

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Kevin R. Hayden, Secretary

January 17, 2008

TO: Senate Committee on Health, Human Services, Insurance and Job Creation
FROM: John Easterday, DHFS administrator of Mental Health and Substance Abuse Services
RE: Senate Bill 375

My name is John Easterday. I am the Division Administrator for Mental Health and Substance Abuse Services at the Department of Health and Family Services. Thank you for the opportunity to testify for information only on Senate Bill 375.

I would like to make brief remarks from the Department's perspective about increasing access to mental health and substance abuse services by removing barriers to these services.

In his 2007-09 biennial budget, Governor Doyle proposed to raise the minimum mandated benefits for mental health and substance abuse services in group and blanket disability insurance policies. These requirements on in-patient, out-patient and transitional hospitalization have not been raised in more than 20 years. We believe it is good public policy to increase access to mental health and substance abuse services to improve good health outcomes for people and to help reduce overall health care costs.

Indisputably, research points to the inter-relatedness of good physical and mental health and substance abuse health care. Not treating a mental illness or substance abuse often leads to diabetes, cardiovascular illness and fetal alcohol spectrum disorders, amongst other diseases. All of these outcomes weigh heavily on our health care system in terms of the health status of Wisconsin citizens and the cost to both insured and uninsured families. This is especially true when we know that that many people who would benefit greatly from these services go without or don't get the full range of services they need.

As the state's largest health care payer, the state provides mental health parity for Medicaid recipients. With the expansion of health care coverage through BadgerCare Plus and Family Care, the state will be increasing access to mental health and substance abuse services that are important to the overall well-being of many of the state's most vulnerable citizens, including many low-income families and senior citizens. DHFS applauds and thanks the Legislature for including these expansions in the budget and therefore increasing access to mental health and substance abuse services.

Mental health parity in some form is the law in roughly 40 states in the country. When crafted appropriately, it can be a win-win for consumers, taxpayers and employers across the state.

We at DHFS look forward to a healthy discussion about removing barriers to mental health and substance abuse services, and we offer our experience as a health care providers, researchers and public health policy makers as SB 375 moves through the legislative process.

Thank you again for the opportunity to provide information. I'm happy to take any questions that committee members may have.

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January 17, 2008

To: Senate Committee on Health, Human Services, Insurance and Job Creation

Re: Support SB 375, mental health parity

Parity means equality. Comprehensive Insurance Parity means benefit equality. Coverage for medically necessary treatment for all mental health and substance abuse disorders provides benefit equality for all Wisconsin workers and families. The League of Women Voters of Wisconsin has supported equality of coverage for mental health treatment for over 15 years. We registered and spoke in support of SB 71 and SB 72 in legislative session 2003-2004. We also supported Senator Hansen's SB 128 in 2005. We are here again in 2008 to support SB 375.

Federal employees have had comprehensive parity since 2001. The prestigious New England Journal of Medicine reported in 2006 that spending on mental health and substance disorders for the population covered either decreased or was unchanged after parity in all of the plans studied.

Mental Health America is a national organization representing families and consumers of mental health programs. They released the findings of an independent research company, International Communications Research, commissioned to conduct an attitudinal survey regarding health insurance coverage. A nationally representative sample of 3,040 respondents age 18 and older was surveyed regarding attitudes toward medical insurance coverage of mental health and substance abuse disorders. They report "the vast majority of Americans (89%) including Democrats, Republicans, managers and employees want to end insurance discrimination against people with mental health needs (http://www.mentalhealthamerica.net/).

The myth that equitable coverage would place too much cost on employers has been disproved in many studies, as the efficacy of treatment for mental health/substance abuse disorders has improved and clearly creates a better workforce. The citizens of this country overwhelmingly support fair mental health insurance coverage. More than 40 states have now legislated equity in coverage. The League of Women Voters of Wisconsin will add our name to the list of organizations in support of SB 375 so that Wisconsin citizens can benefit from the enlightened approach to provide equitable coverage for treatment of mental health and substance abuse disorders.

Testimony of Frank Mixdorf, President, NAMI Wisconsin

Chairman Erpenbach and Members of the Health and Human Services Committee: My name is Frank Mixdorf, and I am the President of NAMI Wisconsin, a not-for-profit organization that provides education, support, and advocacy for individuals and their families who live with mental illness. As part of a national organization, we support local affiliates in 40 Wisconsin counties and have nearly 5,000 members statewide.

Thank you for this opportunity to testify in support of SB 375, the mental health/substance abuse insurance parity bill. Last week, also in support of this bill, I sent a guest column article to 35 daily newspapers in Wisconsin, at least a fourth of which have run it so far, including both Madison papers and the Milwaukee *Journal-Sentinel.*.

With 41 states having already enacted parity, the time has come for Wisconsin to recognize that mental illnesses are biological disorders affecting the brain and need insurance coverage equal to the coverage for any other part of the body.

We recognize that fairness and overcoming ignorance and discrimination may win over hearts and minds, but not always pocketbooks. Therefore, the economics of parity insurance deserve consideration. This is an issue that Wisconsin businesses should favor if they see it is worth their while. I will briefly speak about two studies to support my point, but first let me assert that there are many, many evidence-based studies available on the subject. Therefore, there is no need to rely on theoretical projections based on obsolete information.

First, in a three-year study from Yale University that tracked insurance where access to mental health services was reduced to presumably save costs, the result for those employees was significantly reduced work performance, increased absenteeism, and an increase in general health costs of 37%, when compared with other employees. These trends offset any savings in mental health costs and resulted in no economic benefit to the company.

Secondly, a cost-benefit analysis from a range of industries nationwide found that absenteeism and "presenteeism" decreased when employees were provided with appropriate treatment. In fact for every dollar invested in more thorough mental health treatment, employers gained a minimum return of $1.20 in the form of increased productivity and attendance.

There are many such studies based on solid empirical evidence. The bottom line is that citizens in 41 states and 9 million federal employees including every member of congress would not have parity coverage if it did not make economic sense. So, why would Wisconsin employers <u>not</u> want to provide parity insurance coverage?

Thank you.

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TESTIMONY
SB 375
Senate Committee on Health, Human Services, Insurance, and Job Creation
January 17, 2008

Senator Erpenbach and members of the Committee:

My name is Sarah Bowen. As Executive Director of the Wisconsin Psychological Association and as one of the co-chairs of the Coalition for Fairness in Mental Health and Substance Abuse Insurance, I welcome the opportunity to speak today in support of Senate Bill 375.

My testimony will focus on one point: it costs the state of Wisconsin and its businesses and its healthcare system more when we do not to provide parity in mental health and substance abuse coverage than when we do.

Healthcare economists employ a concept called "the burden of disease" to describe the impact of various disorders on individuals, on the healthcare system, on business and on society. They remind us that there are often even more substantial indirect costs associated with an illness than there are direct costs. The Global Burden of Disease Study conducted by the World Health Organization, the World Bank and Harvard University shows that mental illness ranks second in the burden of disease in our economy.

Approximately 90% of individuals with substance use disorders work. At least 72% of individuals with mental illness work. Using the approach of the healthcare economists, we need to measure cost in a larger context that goes beyond insurance premiums and takes into account such indirect work-related factors as short- and long-term disability, absenteeism, and productivity.

There are many studies supporting the assertion that behavioral health disorders cost our society a lot of money. The Surgeon General reported direct treatment costs for mental illness of $69 billion and indirect costs of $79 billion for 1990. In economic terms, that's a really long time ago. Today, that $79 billion figure would translate to more than $123 billion. While the specific estimates may vary, it is clear that a major portion of the indirect cost is attributed to lost productivity.

Consistently, both economic and healthcare research document that the most commonly treated — and untreated — mental health disorder is depression. Roughly 1/3 of the cost of this disorder is for treatment, and more than 2/3 of the cost is related to absenteeism and lost productivity at work.

A 1999 study documented declines in absenteeism for employees treated for depression. Similar reductions in absenteeism, poor job performance and personnel conflicts were demonstrated following treatment for substance abuse disorders.

- A Connecticut company reduced its mental health services to save money — but what they found was that their general healthcare costs increased, use of sick leave increased, and productivity decreased.
- General Motors estimates it saves $37 million per year by providing Employee Assistance Programs for their workers
- United Airlines estimates nearly $17 return for every dollar spent
- Northrop Corporation reports $20,000 savings per employee who is successfully treated.

The National Business Group on Health has estimated that 181 million workdays are affected by reduced productivity due to mental illness. More than 1.3 billion work days are lost each year due to mental disorders, roughly half the number associated with all chronic physical conditions combined. One study noted that short-term disability claims translate to 18-27.6 days per year. Employers are paying in disability payouts, productivity loss and expenses associated with covering for the absent employee.

In Wisconsin, an estimated 2.08% of commercial insurance claims were filed for major depression, translating to about 17, 300 citizens who sought treatment for depression, and accounting for over 170,500 missed days of work in one year. These numbers are even more significant when we include the fact that they do not include those people who may have depression but have not filed an insurance claim for treatment.

Businesses are paying for mental health and substance abuse disorders whether or not their health plan provides parity. Wisconsin businesses are carrying a heavier indirect burden for these disorders than they would if insurance parity were enacted in our state. Businesses in states that have comprehensive parity laws have expressed satisfaction with these benefits. As one CEO expressed it: "providing mental health benefits on par with physical health benefits is good for the bottom line."

Thank you for the opportunity to appear before you today. I will be happy to answer any questions you may have and to provide any follow-up information you would find helpful.

Mental Health America of Wisconsin

Testimony to the Senate Health and Human Services Committee
SB 375
Shel Gross; Director of Public Policy
Mental Health America of Wisconsin
(formerly the Mental Health Association)

Over the past four years our organization has done a lot of work at the interface between mental health care and primary and acute care. During this time we have come to an appreciation of the impact that mental disorders have on the ability to treat common and prevalent health conditions which employers routinely cover in their health insurance. While others today will address the direct impact of mental illnesses on employer costs and productivity I would like to bring your attention to the indirect, but significant impact that mental health issues have when they impact other disorders. The following information is from the Center for Disease Control and Prevention[i].

Asthma

- People with frequent asthma attacks are more than 3 times more likely to have psychopathology than people with less frequent attacks.
- This psychopathology is associated with more visits to primary care providers, emergency departments and hospitals.
- Cognitive behavior therapy has yielded significant decreases in asthma symptoms.

Arthritis

- Depression is associated with increased activity restriction, increased disability and increased symptoms among individuals with arthritis.
- Combinations of psychotherapy and medication fostered improvement in depressed mood and subsequent improvement in functional status.

Heart Disease

- The risk for developing heart disease in individuals with depression is 1.6 times greater than among non-depressed patients, which is more risk than that conferred by passive smoking.
- Persons with depression are more than four times as likely to have a heart attack than individuals with no history of depression, and are more likely to have medical comorbidities and are at greater risk of mortality.

(over)

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A District Branch of the
American Psychiatric Association

DATE: January 17, 2008

TO: Senator Jon Erpenbach and
Members of the Senate Health & Human Services Committee

FROM: Molli Rolli, M.D., Co-Chair
Wisconsin Psychiatric Association, Legislative Committee
Rachel Molander M.D.
Wisconsin Psychiatric Association

RE: Support of Senate Bill 375

Molli Rolli M.D. Associate Professor, University of Wisconsin, Madison. Co-Director, Inpatient Psychiatry, University of Wisconsin Hospitals and Clinics, Co-Chair, Wisconsin Psychiatric Association Legislative Committee. Chair, Council on Ethics, Wisconsin Medical Society.

Rachel Molander M.D., Resident Physician, University of Wisconsin, Madison, Department of Psychiatry.

This testimony is presented on behalf of our patients, ourselves, the Wisconsin Psychiatric Association which represents 500 Psychiatric Physicians throughout Wisconsin and the Wisconsin Medical Society.

We, like the colleagues we are representing are Physicians who treat patients with serious mental illness. Psychiatrists practice in many settings including hospital-based services, nursing facilities, community-based clinics and programs, along with all the health programs under the auspices of the state government, such as county mental health services, community support programs and state hospitals. Psychiatric physicians also provide service and leadership as academic faculty and practitioners and academic medical centers of excellence and are at the forefront of research on the sources of new treatments for persons with mental illness, including substance use disorders.

First and foremost, we wish to thank Senator Hansen for his ongoing leadership on this issue and we wish to thank you, Senator Erpenbach and Members of the Committee, for your willingness to hold a public hearing on this vital topic.

We have chosen to refrain from making a moral argument about mental health parity. We believe there is a valid moral argument but we have chosen to focus instead on two issues. The first is that mental health parity is good for business. The second is that Mental Health Parity will keep more people working in Wisconsin. Of course, if you wish to hear the moral argument we will be happy to oblige you.

Mental Health Parity is Good Business

Nationwide business is acknowledging the cost of mental illness in the workplace. Employee Benefit News, a leading publication for HR professionals, and the Partnership for Workplace Mental Health, recently released the results of a national survey in which HR professionals from across the country selected mental illness as the health issue that has the most effect on indirect costs to businesses.

The American Psychiatric Foundation's Partnership for Workplace Mental Health program has developed an extensive body of research on the impact of inadequate mental health treatment on productivity and the bottom line for businesses.

More important to this debate in Wisconsin is the contention by some business advocates that increasing mental health benefits would increase costs to business. Given that we are one of only a few states to not have mental health parity, there is a body of research developing that shows no real cost to business when mental health parity is paired with utilization review.

Utilization review is the process insurance companies use to determine if they will agree to pay for a medical expense. Utilization review is the tool insurance companies use to avoid paying for unnecessary medical costs. Increasing the benefit does not give treatment to people who do not need treatment. When benefits increase utilization review insures that only those people in need of treatment get it. For example, hospitalization is generally not approved unless there is actual danger in releasing the patient from the hospital. Now, when a person's benefit has been exhausted the insurance company does not have to pay no matter how dire the situation is. Examples of patients who need to be in the hospital include suicidal patients and patients who are hearing voices telling them to harm other people. When the benefit is gone the payment of the expenses of these people in one way or another goes to the taxpayer.

An excellent example of a study of the cost difference appeared in the New England Journal of Medicine in 2006. It was entitled, "Behavioral Health Insurance Parity for Federal Employees". It concluded that when mental health parity is coupled with utilization review service improves without increasing total costs.

Parity Would Keep More People Working in Wisconsin

When the private sector does not provide adequate mental health benefits the burden of caring for people with serious mental illness is shifted to the public sector.

In our practices we see many people who are on disability who could work if they could get adequate mental health coverage. When a working Wisconsin citizen is stricken with a serious mental illness that requires hospitalization, their insurance policy is allowed to cover only about 4 days of inpatient hospital care in any calendar year. This is not adequate time to treat the most serious mental illnesses. It is very often in that patient's best interest to discontinue their insurance (quit their job) and apply for

disability because Medicare provides superior coverage. We have seen this situation occur countless times.

The lack of mental health parity does not affect the poor. Medicare and Medicaid are superior forms of coverage for mental health issues. Working people are left with no option when they or a family member develops a serious mental health problem than to apply for disability. Few families are wealthy enough to afford the out of pocket expenses required to treat a serious illness. In effect we end up "throwing in the towel" on a return to gainful employment before we have had a chance to treat the illness. Once a person gets disability their chance of returning to gainful employment is very small. It is common for our patients who could return to work, to avoid getting work because they would no longer be able to afford the treatment they need when they switch from Medicare or Medicaid to private insurance.

While the parity law won't remove every barrier to mental health, it will be a step forward and the Wisconsin Psychiatric Association hopes that this legislature will move this important legislation through both houses and pass legislation this session. Thank you in advance for your consideration. We will be happy to answer any questions you may have.

ONDCP Medical Education in Su
Leadersh
FI

NIAAA National Institute on Alcohol Abuse and Alcoholism

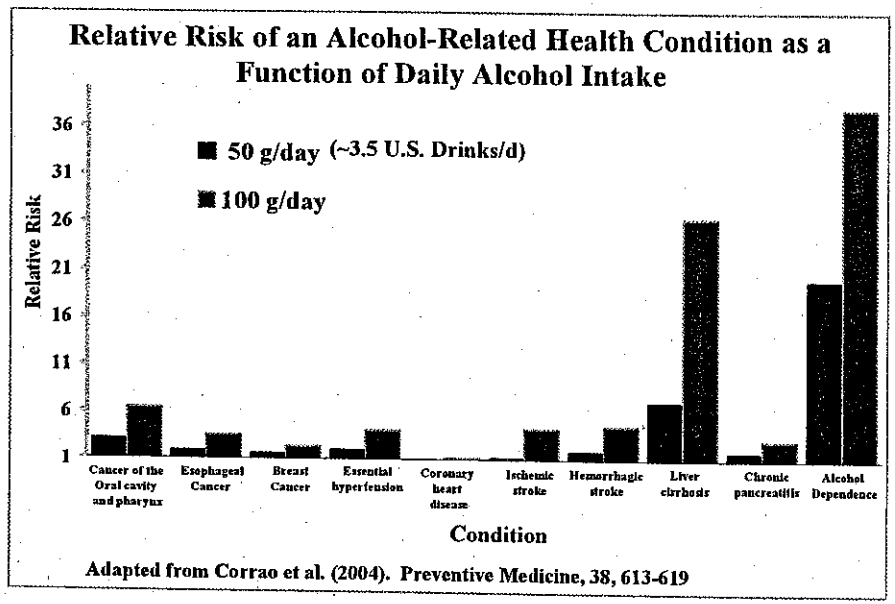
Screening and Brief Intervention: Reducing the Burden of Harmful Alcohol Use on Public Health

T.-K. Li, M.D.
Director
National Institute on Alcohol Abuse and Alcoholism

Third National Leadership Conference on Medical Education in Substance Abuse
Washington, DC
January 16, 2008

Relative Risk (RR) of Chronic Consequences and Daily Alcohol Intake

- **Chronic excessive drinking leads to increased relative risk (RR) by at least 50% for all-cause mortality between 50-100g ethanol/day**
- **Variations in RR by gender, age etc.**



Adapted from Corrao et al. (2004). Preventive Medicine, 38, 613-619

Gmel et al. (2003). Eur J Epidem. 18(7) :631-42

1/9/2008

4

Additionally, for employers, while parity may require slightly more up-front spending on behavioral healthcare services, it could save two to three times the extra expenditures in reduced absenteeism and disability costs, lower accident rates among employees, and improve productivity in the workplace.

Policy Wrangling

Estimates of the potential industry-wide cost increases from mandated behavioral healthcare parity have fallen from 3% or 4% in the early 1990s to 0.6% or lower today, based on a recent Milliman study. The 0.6% cost impact of parity is based on a scenario that assumes plans do not increase their utilization management of behavioral benefits. If all plans increased their utilization management in response to mandated parity, costs could rise by less than 0.1%. The Congressional Budget Office agrees, recently reporting a 0.4% estimated cost impact. None of these analyses consider the effect of cost offsets from savings in other healthcare services, such as the potential for reduced visits to primary-care doctors or emergency rooms. All of these estimates are aggregates, and the impact for particular programs can vary.

As a result of parity, cost increases could be as high as 2% to 3% for some plans, such as those without managed care that have very little existing behavioral healthcare coverage. But these plans make up less than 5% of all group plans.

Two competing bills in Congress that would establish parity, S.558 in the Senate and H.R.1424 in the House, have received objections on the basis that attempts to achieve parity would result in runaway costs. But according to the Milliman analysis, the House's more extensive Wellstone Act would raise individual premiums by between $0.03 and $2.40 per insured person per month.

Today, as treatment costs have continued to fall dramatically in the carve-out sector, the parity argument is no longer over high costs or whether it is the right thing to do, but over which parity bill in Congress is better. The House bill is a bit more comprehensive than the Senate bill, but projected costs are comparable. To an outsider, the debate has apparently shifted from costs to politics.

Parity would help improve access, but what's really needed is an integrated healthcare delivery system, one where medical and behavioral healthcare providers deliver coordinated healthcare in a collaborative fashion. Evidence is beginning to suggest that the long-term costs of not treating behavioral health problems, or solely treating them in isolation from other medical issues, may result in total healthcare costs that are much higher than necessary. In medical settings, patients may seek repeated and ineffective care from medical or surgical physicians, rather than more effective specialized care from specialty behavioral professionals.

Twenty-five percent to 40% of patients with a chronic, costly physical condition also have a diagnosable psychological disorder—that's a rate 50% to 100% higher than in the general population, and these are often severe cases.[5] What's more, a disorder like depression can exacerbate a physical illness and lead to increased medical costs. Integrating behavioral healthcare with the rest of the mainstream healthcare system may help catch these double-whammy situations before they do lasting damage to patients and drive up overall healthcare costs. This is the second part of the transformation beginning to occur in the delivery of behavioral healthcare.

Changing the Status Quo

Three core elements of the behavioral healthcare system must each be altered in order to achieve a truly integrated approach:

- Benefit financing, which parity goes a long way toward improving
- Integrated case and disease management that addresses patients with physical and behavioral disorders
- Day-to-day recognition and responsibility for both physical and behavioral outcomes by all treating clinicians

Many healthcare professionals now argue that ineffective or nonexistent behavioral treatment negatively affects the healthcare system as a whole—and the employers and workers who support and depend on it. This hypothesis is gaining support, although the longitudinal studies to provide conclusive evidence of this are still in the early stages.

Fully integrating the behavioral health system with the rest of the mainstream healthcare system could take a generation to complete, just as it took a generation for the MBHOs to prove that specialty behavioral healthcare could be provided at a reasonable cost. But for the time being, the 92 patients out of 100 diagnosable ones who aren't getting minimally effective treatment are adding costs to health plans and the employers who sponsor them.[6,7,8] M

STEPHEN P. MELEK *is a principal and consulting actuary with the Denver office of Milliman. He has extensive experience in the behavioral healthcare specialty field and has focused on parity issues (including recent Congressional testimony) and cost analyses, mental health utilization and costs in primary-care and emergent settings, psychotropic drug treatment patterns and application of quality algorithms, and strategic behavioral healthcare system design.*

2 Narrow et al., op. cit.
3 Wang et al., op. cit.
4 Milliman proprietary research.
5 W. Katon, M. Von Korff, E. Lin, P. Lipscomb, J. Russo, E. Wagner, E. Polk, "Distressed High Users of Medical Care: DSM III-R Diagnoses and Treatment Needs," *General Hospital Psychiatry*, 1990.
6 R.C. Kessler, O. Demler, R.G. Frank, et al., "Prevalence and Treatment of Mental Disorders, 1990 to 2003," *New England Journal of Medicine*, 2005.
7 W.E. Narrow, D.S. Rae, L.N. Robins, D.A. Regier, "Revised Prevalence Estimates of Mental Disorders in the United States: Using a Clinical Significance Criterion to Reconcile Two Survey Estimates," *Archives of General Psychiatry*, February 2002.
8 P.S. Wang, O. Demler, R.C. Kessler, "Adequacy of Treatment for Serious Mental Illness in the United States," *American Journal of Public Health*, 2002.

Testimony to the Committee on Health, Human Services, Insurance, and Job Creation
Wisconsin State Senate

Regarding

Mental Health and Addiction Parity
Senate Bill 375

Presented by
Michael M. Miller, MD, FASAM, FAPA
Medical Director, NewStart Alcohol/Drug Treatment Program
Meriter Hospital, Madison, WI

Associate Clinical Professor
Departments of Family Medicine, Psychiatry, and Internal Medicine
University of Wisconsin School of Medicine and Public Health

Past President, Wisconsin Society of Addiction Medicine
Current President, American Society of Addiction Medicine

Past President, Dane County Medical Society

Recent Board Member
Wisconsin Medical Society and Wisconsin Alcohol and Drug Treatment Providers Association

January 17, 2008

Chairman Erpenbach and Distinguished Members of the Committee:

Ladies and gentleman, thank you very much for allowing me to share some information with you relevant to the legislation before you today. And I am pleased to report to you that my own employer, Meriter Health Services of Madison, one of Wisconsin's largest employers, now supports parity for mental health and addiction benefits, so I am testifying today on behalf of Meriter as well.

I practice medicine full time at Meriter Hospital in Madison. My specialty is addiction medicine. I am also board certified in general psychiatry and addiction psychiatry. I've practiced these specialties in Wisconsin for almost 25 years. I am on-call today at the hospital and I am most appreciative of you, Chairman Erpenbach, accommodating me today. I'm proud to be a constituent in your district.

In the progressive Wisconsin tradition, Wisconsin at one time was a pioneer and trendsetter in mental health insurance reform. Thirty years ago, when many insurance plans included no coverage for psychiatric or AODA care, Wisconsin's mandated benefits law required private

insurers to include at least $6300 of coverage per year for these conditions. Now, virtually no public or private employee in America has an insurance plan that contains no mental health or addiction benefits at all. And now, Wisconsin is behind the times. Federal employees have full parity for addiction and psychiatric care in the FEHBP. State employees in North Carolina and many states have full parity. Citizens in Vermont have full parity. Over 35 states have some degree of parity mandated by law into private health insurance benefits. Wisconsin does not. It is time to bring Wisconsin employees up to par, as Senate Bill 375 would do.

I have presented testimony before the legislature for several years on these topics because mental health and addiction parity legislation has been before legislature many times before. The usual approach has been for me to speak as a practicing physician and as Chair of the public policy Committee of the American Society of Addiction Medicine, talking about the patients I treat, addressing how addiction is a brain disease, addressing the health impacts of substance use and addiction, and how irrational and unfair it is that health insurance pays for treatment for some brain diseases such as Parkinson's disease and epilepsy in the same way that is pays for heart disease and cancer, but it pays for the treatment of other brain diseases such as manic depressive illness and alcohol addiction, in a very discriminatory way. I am not here today to discuss issues of fairness and biology. But I am here to share with you some thoughts on why it's important for Wisconsin business to pass mental health and addiction parity legislation.

First, is parity affordable? I have testified previously before the Legislature about how there is EVIDENCE from parity implementation in other states, about what it will cost to include full parity for mental health and addiction benefits. In previous years, I warned you to listen for testimony from so-called 'business interests' who would provide inaccurate numbers on how much premiums would rise if Wisconsin were to adopt parity. The facts are, from observing parity in other states, that parity for MH benefits increases premiums 0.3-0.7%, and parity for AODA benefits raises premiums even less, only 0.1-0.2%. We can expect that Senate Bill 375 would raise health insurance costs 0.4-0.9%. This is a small price to pay for equality.

Addressing the health problems of addiction to alcohol and other drugs, and the health problems caused by substance use and addiction, is very relevant to the business community, because over 60% of Americans and Wisconsinites with drug addiction are employed, and about 80% of problem drinkers are employed. These individuals are in the workforce and are covered by employer based health insurance plans. You all know the contribution of health insurance as an employee benefit that affects the bottom line of Wisconsin employers.

The historical response to alcohol use in the workplace was to dismiss employees who caused workplace accidents while under the influence while on duty; to eliminate from consideration potential employees who had positive pre-employment urine drug tests; to dismiss employees who had repeated positive urine drug tests; and to otherwise ignore alcohol and drug use among workers – sometimes assuming that alcoholism wasn't a significant issue for the employees of MY company, or considering even alcoholic patterns of drinking outside the workplace to be a private matter and an aspect of the employee's personal life but not his or her work life.

Some well-publicized alternative approaches included having HR policies that prohibited tobacco smoking for any employees, even during off-work hours, considering the burden of

health care costs generated by the employee to be too great to bear – so refusing to recruit or retain employees who were addicted to tobacco.

The most enlightened employers now know that addiction to alcohol and other drugs is very relevant to the health of the company and not just the health of employees or dependents. Employees impacted by, and distracted by, addiction in themselves or in a life partner, a child, or a parent, are unable to do their best for their employer, and contribute to workplace errors (in both white collar and blue collar occupations) as well as workplace absenteeism, tardiness, and injuries. The term PRESENTEEISM has come to be used along with the term ABSENTEEISM to capture the problems in workforce productivity by workers who are under the influence, 43 recovering from being under the influence, preoccupied during work with obtaining drugs after work, preoccupied with a loved ones addiction – or even spending work hours surfing the Internet to locate on-line supplies of pain killers or tranquilizers.

The latest estimate of the costs of alcohol problems in the United States are close to $200 billion/year. While more than $50 billion is due to excess healthcare costs, vehicular crashes, property loss, and crime, the cost to business of untreated addiction to alcohol alone is almost $150 billion/year associated with lowered productivity due to absenteeism, presenteeism, disability and job turnover. Please note that of the healthcare dollars spent by employers in the US on addiction, well under 5% is spent on addiction treatment itself, while over 95% is spent on treating the medical/surgical and psychiatric complications – the injuries and illnesses caused by substance use and addiction.

Employers now know that retaining skilled workers is far less expensive than dismissing them and recruiting and training new ones. Rehabilitation of an employee with addiction makes more business sense than dismissing the employee. Employee Assistance Programs are designed to provide early identification of cases of mental health and substance use disorders, and to provide intervention and referral services to employees with mental health and substance use problems – and to get patients treated through effective treatment services so they can return to work more functional than ever.

Data is clear that healthcare utilization for addicted employees is much lower after an episode of addiction treatment versus prior to the addiction treatment episode – and often, prior to the addiction treatment episode, the employer and the front line supervisor were unaware of the person's addictive disease. The supervisor may be aware of performance or attendance issues. The Chief Financial Officer maybe aware of the employee's healthcare utilization data. But without identification of the AODA problem, the linkages between an addictive disease and suboptimum financial performance for the employer would not be appreciated.

In 2006, over 60% of full-time employees aged 18 or older drank alcohol. Among 16 million risky drinkers in America, almost 13 million were employed. Low and high risk alcohol users cover a larger percentage of the drinking population than people who are actually addicted to alcohol. Yet, these moderate drinkers caused 60% of alcohol related absenteeism, tardiness, and poor work quality. In addition, reports estimate that up to 40% of industrial fatalities and 47% of industrial injuries are linked to alcohol use. Misuse of alcohol is linked to almost 50% of all

trauma and injury-related emergency room visits, which tends to increase employers' health insurance expenditures and drive up the costs of insurance premiums.

When large and small employers, alike, help their employees address alcohol problems by offering appropriate services that include screening and brief intervention, they are likely to experience lower healthcare cost growth rates, and a return on investment of at least 2.1% (Eric Gopelrud, PhD, Ensuring Solutions, George Washington University).

Employers have traditionally looked at the costs of mental health and addiction treatment, and seen them as "cost-added" for the employer. But especially in the case of addiction care, addiction treatment is clearly value-added. The current question for employers who understand the data is, how can an employer afford NOT TO TREAT addiction in his/her employees?

Recall that the healthcare costs associated with substance use and addiction are greater than 95% due to the cost of treating the complications of substance use and addiction – addiction treatment costs are less than 5%. Only $8 billion dollars/year is currently spent on treatment of addiction out of the $2 trillion dollars spent on health care services on our nation, because only a fraction of persons with addiction who need treatment, receive treatment. In the health services research literature, this is referred to as the "treatment gap." America and Wisconsin cannot afford to sustain this treatment gap. This is why the federal Healthy People 2010 Report, and the State of Wisconsin Department of Health and Social Services Healthiest Wisconsin 2010 Health Plan, both have specific sections devoted to narrowing the treatment gap for addiction.

One reason for the treatment gap is a lack of health insurance coverage for addiction treatment. Please be aware that the value of private health insurance benefits for addiction treatment have lost over 75% of their value in the last 25 years. The Wisconsin mandated benefit of $6,300 dollars a year total, for mental health and addiction costs, has not risen in the 30 years since the hallmark legislation was passed mandating psychiatric and AODA care. Employees in Wisconsin who have excellent insurance for their general health care needs are virtually all under-insured for mental health and addiction care. Note also that in our current economic environment, the private sector has basically abandoned persons with addiction. Of all of the dollars spent on addiction treatment in our nation, 76% are paid for by the public sector. Only 9% of treatment costs are bourne by private insurance payments. This involves a tremendous cost shift from the private sector to the public sector – which means, to the tax payer. The public sector pays for a much larger percentage of addiction treatment than it does cancer treatment or diabetes treatment. Without parity of the kind that would be created by the legislation before you today, commercial insurers believe that there will be adverse selection of policies that have more generous coverage for mental health and addiction. Employers face the same dilemma – no one wants to be the first to offer more generous benefits and put themselves at a perceived economic disadvantage. We need to have a level playing field. Employers are motivated by such arguments despite the reality that parity for addiction care saves $7 for every dollar spent, based on numerous studies from various parts of the country.

Yesterday I was in Washington, DC, for a White House sponsored conference on screening and brief intervention for alcohol problems, and the data presented there is that the cost benefit

analysis shows that for every dollar spent on screening and brief intervention in the workplace or in health care settings, $4 is saved. So this really is value-added service.

I would like to share with you some data I received at the conference yesterday in our Nation's Capitol, presented by the Director of the National Institute on Alcohol Abuse and Alcoholism. His data shows what a huge contributor mental health and addiction problems are to disability in our nation. The statistic used is called Disability Adjusted Life Years, or DALY. Of the ten leading causes of DALY's in the United States, heart disease and stroke were number one and two, but depression was number four, alcohol was number seven, and motor vehicle crashes were number three – and we know how many auto crashes are attributable to alcohol. Of the actual causes of death in the United States, number one is tobacco – (this is an addiction). Number two is poor diet and physical activity leading to obesity. And number three is alcohol consumption. We are not talking about rare or irrelevant health conditions – we're talking about the "horses" here, not the "zebras." If we want to reduce overall healthcare costs we must give people ready access to treatment for alcohol problems, because of the contribution of drinking to health outcomes for a wide range of health care conditions, including cancers, high blood pressure, stroke, as well as cirrhosis of the liver. Why give people access to full insurance coverage for high blood pressure and tell them to watch their diets, and deny them access to alcoholism care, when the data show that a person's alcohol use contributes just as much risk to their blood pressure as does their salt intake! (PRISM Project, A.T. McLellan, PhD, University of Pennsylvania)

Parity is also wise in this way: a patient with diabetes and depression costs twice as much to treat on average as a diabetic who is not depressed. Untreated psychiatric and addiction problems make it more expensive to treat almost any chronic medical problem, driving up employer costs. The best way to save employer dollars on health care costs is to pass Senate Bill 375 and remove barriers to access to effective treatment of psychiatric and substance related disorders, so the care of chronic diseases by internists and family physicians can generate optimum results most efficiently.

At this National Leadership Conference I attended this week sponsored by the White House Office on National Drug Control Policy, we were given an article hot off the presses from the American Journal of Preventive Medicine. What this shows is that screening and counseling regarding alcohol use is just as important a preventive intervention as more commonly known interventions. Among 25 preventive interventions studied by the US Preventive Services Task Force, alcohol misuse got a score that was similar to screening for colorectal cancer, hypertension, and influenza immunization. In other data presented at this Conference, the most effective prevention intervention is to have people stop smoking. The second is to provide aspirin for a heart attack patient. Number three of all prevention interventions as far as effectiveness, is screening and brief intervention for alcohol problems. It's more effective, in some studies, than colorectal cancer screening and vaccinations for pneumonia and influenza, and even more effective than pap smears, mammograms, and prostate cancer screening. Anyone screening "positive" should be referred to treatment. With parity, treatment will be affordable and available.

Given this compelling data, we cannot afford to have barriers to access to care for alcoholism. We cannot afford to continue the status quo, without parity, where patients can't get their alcoholism treated in ways that will save them and their family untold pain, and their employer significant real dollars.

How has American business, and Wisconsin business, dealt with alcoholism and drug addiction treatment historically? Employees with a child who has cocaine, heroin, Vicodin, marijuana, or alcohol addiction or anorexia nervosa, will call their family doctor – and their doctor will say, "I don't know where there are services I could refer you to." They contact their Employee Assistance Program, who gives them a name a treatment center. They call HR and check their benefits. And they see that for cancer, heart disease, diabetes, and other brain diseases, there are full benefits, but for alcohol and other drug addiction, another disease of the brain, there are very limited benefits. Wisconsin mandated benefits will pay for three days of hospital costs, or 10-15 days of residential treatment costs, or 30 days of intensive outpatient treatment costs – with no dollars left at all for the ongoing care that we know is needed after primary treatment to keep this chronic illness in remission. So, if someone in the family needs residential treatment, the employee is left to self-pay for it basically – with the money required presenting them a significant financial burden.

What happens if CEO has a family member with the same problem? They realize that their health insurance wont pay for it so they just dip into their savings account and self-pay for care, even at more expensive programs such as the Betty Ford Center or other out-of-state programs. So what happens today – the CEO gets care, and the front line employee doesn't get care because of financial barriers. Is this fair? The parity legislation before you will address this.

So I don't have a degree in business or economics – I'm just a practicing physician here in Madison. But I care about these topics because they affect the real lives of real people in my practice every single day and they affect the economic health of businesses in Wisconsin.

To reiterate, please recall, the FACTS are, from observing parity in other states, that parity for MH benefits increases premiums 0.3-0.7%, and parity for AODA benefits raises premiums even less, only 0.1-0.2%. We can expect that Senate Bill 375 would raise health insurance costs 0.4-0.9%. I have included with my testimony a copy from an article by Milliman confirming this fact—and you know that Milliman is one of the best sources of consulting advice to businesses large and small.

Let's do what's right for Wisconsin employees and EMPLOYERS. Let's level the playing field for all businesses and health plans, set the standard for coverage uniformly across the marketplace, and pass this AFFORDABLE legislation which will return more addiction and psychiatric care to the private sector and lower the burden on state and county governments for providing this necessary medical care.

WAFCA
Wisconsin Association of
Family & Children's Agencies

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Linda A. Hall
Executive Director

TO: The Honorable Members of the Senate Committee on Health, Human Services, Insurance and Job Creation

FROM: Linda A. Hall, Executive Director

DATE: January 17, 2008

RE: Senate Bill 375 – Mental Health Parity

The Wisconsin Association of Family & Children's Agencies (WAFCA) strongly supports passage of Senate Bill 375, which would require health insurers to provide equal coverage of mental health and physical health care services.

WAFCA represents over forty private for-profit and nonprofit agencies that provide mental health, education and social services to people in need. Our members' services include family, group and individual counseling, chemical dependency treatment, crisis intervention, domestic violence programs and outpatient mental health therapy, among others. The majority of our agencies' work with families is supported by the public through Community Aids, Medical Assistance and local tax dollars.

As providers of mental health services, our members are daily witnesses to the struggles of fragile families facing mental health and substance abuse issues. As employers of over 10,000 staff statewide, our member agencies are also acutely aware of the impact that rising health care costs have had on their capacity to provide services and their ability to offer affordable, quality health care coverage to their employees.

While many have argued that mental health parity will impose additional costs on employers, there is considerable evidence that improving access to mental health services makes sense both economically and socially. Employees are more productive and parents are more effective when they have timely, affordable access to quality mental health care.

The current mental health insurance coverage requirements were intended to offer some assurance that individuals would be able to use their health insurance to access mental health services when needed. Unfortunately, the minimum coverage amounts established in 1992 have been treated like maximums. With no increase in the statutory coverage levels, the minimum amount set 16 years ago purchases significantly less service today. When individuals face insurance limits, they are unable to achieve stability and remain healthy enough to maintain employment.

The benefits of mental health parity extend well beyond the immediate benefits for individual families and businesses, however. Increasing private insurance coverage for mental health services increases early and appropriate access to services, thus reducing cost shifting to government.

According to DHFS data reported through the Human Services Reporting System, in 2005, expenditures on mental health and substance abuse services for county clients exceeded $445 million in state and local funds. An analysis of health care reform by the Lewin Group (1994) determined that approximately 20% of public reimbursements for health services are for clients that have private health insurance coverage. Using the Lewin Group's measure, $85 of that $445 million were public dollars filling the gap left by private and employer sponsored insurance. In 2008, the public dollar expenditure will certainly be higher.

Full coverage of mental illness and substance abuse treatment is not just about allowing a few people to access "extra" services that they can really get along without. It is about allowing people access to services that will improve their health status, reduce their use of physicians and hospitals for symptoms related to their mental illness, reduce government expenditures and reduce the number of parents and children who end up in corrections or child welfare because their illnesses are not addressed.

We urge your support for SB 375 to provide mental health parity, a policy that will serve the best interests of Wisconsin families, Wisconsin workers, Wisconsin businesses and Wisconsin taxpayers.

REPRESENTING WISCONSIN BUSINESS

Wisconsin Manufacturers & Commerce

Wisconsin Manufacturers' Association • 1911
Wisconsin Council of Safety • 1923
Wisconsin State Chamber of Commerce • 1929

James S. Haney
President

James A. Buchen
Vice President
Government Relations

James R. Morgan
Vice President
Marketing & Membership

Michael R. Shoys
Vice President
Administration

To: Chairperson Jon Erpenbach
Members of the Senate Committee on Health, Human Services, Insurance and Job Creation
From: R.J. Pirlot, Director of Legislative Relations
Date: January 17, 2008
Subject: **Opposition to Senate Bill 375**, relating to health insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems.

Under current law, fully-insured Wisconsin employers must provide a minimum level of coverage for treatment of nervous and mental health disorders and of alcohol and other drug abuse problems. SB 375 will remove these minimum coverage limits and, instead, require group health benefit plans to "provide the same coverage" for treatment of nervous and mental health disorders and of alcohol and other drug abuse problems that the plan provides for the treatment of physical conditions.

The Office of the Commissioner of Insurance has not released a financial analysis of this new mandate. Regarding a similar mandate, last session, past-Insurance Commissioner Jorge Gomez estimated such a mandate would increase health care insurance premiums, statewide, by up to $36.6 million.

SB 375 Will Raise Health Care Costs, Jeopardizing Affordability

Government insurance mandates inevitably lead to higher health care insurance costs, meaning employers and employees will have to pay more for health insurance coverage. As health care insurance costs go up, typically the hardest hit are Wisconsin's small businesses and their employees. Rising health care costs are already forcing Wisconsin employers to shift health care cost increases to their employees, reduce health care coverage, or both. SB 375 will make the affordability problem worse.

SB 375 Will Jeopardize Access to Health Care Insurance

As health care insurance costs rise, fewer and fewer individuals and businesses can afford to buy health care insurance. An increase in premium costs to employers will have a negative effect on the number of people insured in Wisconsin. Only 26 percent of the Wisconsin population will be affected by SB 375, the population that depends on state-regulated health insurance plans for their coverage. This population is declining as health care insurance costs rise. Wisconsin businesses and their employees are already struggling to help pay for employee health care benefits. SB 375 will make the access problem worse.

Health Care Costs Are Rising and Hurt Economic Development

Rising health care insurance costs are a major concern for businesses, big and small, as they strive to stay competitive. Rising health care costs undermine the ability of Wisconsin companies to offer health care benefits and, significantly, impede their ability to create and retain good-paying jobs in Wisconsin. Again, SB 375 will make the access and affordability problems worse.

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NFIB
The Voice of Small Business®

Wisconsin

MEMORANDUM

TO: **Members of the Senate Committee on Health, Human Services, Insurance and Job Creation**

FROM: **Bill G. Smith, State Director**

DATE: **Thursday, January 17, 2008**

RE: **Senate Bill 375**

I regret I am unable to attend today's hearing, but please consider the following statement on behalf of NFIB's 12,000 member firms.

Studies show the impact of health insurance costs is not only causing small business owners to adjust cost sharing, cancel coverage's, and reduce coverage, but the high cost of health insurance is also having a serious negative impact on our state's economy.

While some will argue SB-375 will have minimal impact on the cost of health insurance, studies show a mere 1 percent increase in the cost of a health insurance plan equals a $36 million increase in premium cost for Wisconsin's employers who purchase group health insurance. The Office of the Insurance Commissioner has analyzed the impact of mental health and substance abuse mandate legislation and concludes:

Higher Health Insurance Costs

"The mandate will add approximately $9.2 – 30.8 million per year to group insurance consumers, borne mostly by small businesses." (emphasis added)

More Uninsured

"...it is reasonable to assume that an increase in premium costs to small and medium-sized employers will have a negative impact on the number of people insured in Wisconsin."

Of course, because federal ERISA law preempts self-insured plans from state mandates, **self-insured big businesses will not be affected by this legislation.**

Senate Bill 375 will increase health insurance premiums for small business and cause more Wisconsin citizens to lose their health insurance coverage.

On behalf of our states small business owners who are already struggling with the cost and coverage of their existing health plans, I hope you will support proposals that make health insurance more affordable not less affordable for our states small employers and their employees.

Please vote against recommending Senate Bill 375 for passage. Thank you for your consideration.

National Federation of Independent Business — Wisconsin
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WISCONSIN CATHOLIC CONFERENCE

TO: State Senator Jon Erpenbach, Chair
Members, Senate Committee on Health, Human Services, Insurance, and Job Creation

FROM: John Huebscher, Executive Director

DATE: January 17, 2008

RE: Senate Bill 375, Mental Health and Substance Abuse Parity

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On behalf of the Wisconsin Catholic Conference, the public policy voice of Wisconsin's Roman Catholic bishops, I wish to express our support for Senate Bill 375. This bill would enhance health insurance coverage requirements in Wisconsin for mental illness and substance abuse, ensuring that those who suffer from these conditions receive the same care and treatment as those who have physical health issues.

SB 375 proposes a sensible policy that reflects medical science's current understanding of the intricate link between mental and physical health. Mental health conditions and substance abuse can be as debilitating as any physical injury, and yet, those who suffer such affliction have traditionally not received the same opportunity to access treatment.

This bill corrects that inequity by removing the state's minimum coverage amounts for group health insurance for these conditions and instead requiring that group insurers provide the same coverage for the treatment of mental health and substance abuse conditions as they would for any physical ailment. The bill also ensures that certain individual plans that opt to provide mental health and substance abuse coverage do so in a manner that is equivalent to the coverage provided for the treatment of physical conditions.

The human person is more than a physical body. Our human nature blends the physical with the intellectual and spiritual. The latter two may be harder to quantify but are no less deserving of our attention. Further, each of us possesses an innate dignity with which, in the words of the Founders, we are endowed by the Creator. This human dignity is present even when one is physically, mentally, or emotionally afflicted.

Since all of us suffer when illness robs our neighbor of his or her ability to contribute to the community, we have a shared responsibility to support those who find themselves in a condition of serious mental illness. The mental health needs of our neighbors, no less than their physical well-being are a proper concern of public policy. It is, therefore, appropriate for laws to foster greater equity in how we deal with mental and physical illness.

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Tel 608/257-0004 • Fax 608/257-0376 • Website http://www.wisconsincatholic.org

Proper treatment of mental health and substance abuse not only serves the human dignity of the individual afflicted with a condition or addiction; it also serves to enhance the safety and security of our communities. Indeed, one of the issues that continually surfaced as the bishops studied the issue of crime and the criminal justice system in this state was the percentage of prisoners with mental illness and addictions. Mental illness and substance abuse issues also clearly intertwine with other social concerns such as poverty.

Establishing parity coverage for those who suffer from substance abuse, mental health issues, and physical illness, recognizes the fullness of the human person and fosters a consistent life ethic. These are worthy policy objectives.

We respectfully request your support for SB 375 and thank you for your consideration.

TESTIMONY BY NASW WI EXECUTIVE DIRECTOR MARC HERSTAND ON SENATE BILL 375 TO THE SENATE COMMITTEE ON HEALTH, HUMAN SERVICES, INSURANCE AND JOB CREATION ON JANUARY 17, 2008

Chairperson Erpenbach and members of the Senate Committee on Health. Thank you for this opportunity to present testimony on Senate bill 375, the mental health/substance abuse parity bill.

My name is Marc Herstand. I have served as the Executive Director of the National Association of Social Workers, Wisconsin Chapter for over 15 years. NASW WI represents over 2300 social workers throughout the state of Wisconsin who work in hospitals, outpatient mental health clinics, county human service departments, nursing homes, community based organizations, school districts, colleges and universities, state government, business and other settings.

In addition to representing NASW WI, I am also one of several speakers today representing the Fairness Coalition for Mental Health & Substance Abuse Insurance.

The Fairness Coalition has been working to get a mental health and substance abuse parity bill passed for close to ten years. Over the years we have presented information about the need for full coverage, and the terrible hardship on families who lack this coverage. We have provided information about the health care costs and costs to businesses of untreated mental illness and substance abuse.

One of the persistent arguments against mental health/substance abuse parity has been the concern that increasing the amount of coverage from the current minimum mandate would increase costs to businesses in Wisconsin.

While in the past we did not have a lot of research addressing the cost issue, that is not true today. In my comments today I would like to briefly present some of the most recent research on the cost issue.

First since 1999 federal employees have had full mental health and substance abuse parity. In 2006 the New England Journal of Medicine published a study entitled, "Behavioral Health Insurance Parity for Federal Employees" that compared Federal Employee Health Benefit plans over a three year period with other health plans that do not have mental health and substance abuse parity. The conclusion of this very detailed study was that when coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

Secondly, again in 2006, the journal Health Affairs published an article entitled, "The Costs of Mental Health Parity: Still an Impediment". This article examined authoritative studies of the

effects of mental health care benefit changes. What the study found was that the relevant research implies that parity implemented in the context of managed care would have little impact on mental health spending and would increase risk protection. One of the studies examined in the article was from the Congressional Budget Office which estimated that comprehensive parity would raise premiums between .4 and .9 %.

In addition to these studies of federal employees and other health plans, there have been a number of studies of the impact of the implementation of mental health and substance abuse parity from specific states.

The National Conference of State Legislatures reported in 2002 that in the State of Minnesota, which has had parity since 1995, cost rose just 26 cents per member. The U.S. Department of Health and Human Services reported that in Vermont, which has had comprehensive parity since 1999,one major insurer reported that cost increased 19 cents per member after parity, while another insurer reported costs had decreased. In 2004 Price Watterhouse Coopers conducted an actuarial analysis of comprehensive mental health parity for the State of Washington and found that the expected Net Insurance Impact for health costs will rise about 0.44 % or $1.17 per member per month.

I would be happy to share complete copies of the studies I have referenced in my testimony.

In conclusion while some groups and legislators might have philosophical reasons to oppose mental health/substance abuse parity, as I hope I have demonstrated in my testimony, opposition to mental health and substance abuse parity on the basis of increased total spending is no longer supported by any research or evidence.

Please pass SB 375.

MENTAL HEALTH PARITY NOW!

1. AARP Wisconsin
2. AFL-CIO
3. AFSCME Council #24
4. American Federation of Teachers (AFT) - Wisconsin
5. American Heart Association
6. American Society of Addictive Medicine - Wisconsin
7. Anorexia Nervosa & Associated Disorders
8. Archdiocese of Milwaukee, Social Concerns Office
9. Associated Counseling & Recovery Center LLC - Fond du Lac
10. Association of School Boards
11. Autism Society of Wisconsin
12. Bulimia Education & Support Training
13. Catholic Health Association of Wisconsin (CHA-W)
14. Citizen Action of Wisconsin
15. Coalition for Fairness in Mental Health and Substance Abuse Insurance
16. Coalition for Wisconsin Health
17. College of Nursing - Marquette University
18. Consumers of Positive Effect
19. Cornucopia
20. Cyber Phoenix Project
21. Dane County Chemical Dependency Consortium
22. Dennis Hill Harm Reduction Center
23. Depression and Bipolar Support Alliance
24. Disability Rights of Wisconsin
25. Earth Angels Training Team
26. Elkhart Psychological Services
27. Employee Assistance Professionals Association - South Central Wisconsin
28. Employment Resources, Inc.
29. Encompass-Effective Mental Health Services
30. Epilepsy Foundation of South Central Wisconsin
31. Epilepsy Foundation of Southern Wisconsin
32. Epilepsy Foundation of Western Wisconsin
33. Family Planning Health Services, Inc.
34. First Congregational Church Forum - Madison
35. Friendships Unlimited
36. Genesis 1990
37. Grand Avenue Club
38. Grassroots Empowerment Project

39. Gundersen Lutheran
40. Hispanic Chamber of Commerce - Wisconsin
41. Inacom Information Systems
42. Independent Care Health Plan (iCARE)
43. InHealth WI
44. Interfaith Conference of Greater Milwaukee
45. International Association of Psychological Rehab Services-Wisconsin
46. Jewish Family Services - Milwaukee
47. Koller Behavioral Health Services
48. Lutheran Office for Public Policy in Wisconsin
49. Managed Health Services (MHS)
50. Matt Talbot Recovery Center
51. Medical College of Wisconsin
52. Mental Health America of Wisconsin
53. Mental Health Center of Dane County, Inc.
54. Mental Health Coalition of the Greater La Crosse Area
55. Mental Health Consumer Network
56. Milwaukee Area Health Education Center (AHEC)
57. Milwaukee Coalition on Mental Illness
58. Milwaukee Jewish Council for Community Relations (MJCCR)
59. Milwaukee Mental Health Task Force
60. Ministry Health Care – Saint Clare's Hospital
61. NARAL Pro-Choice Wisconsin
62. National Alliance on Mental Illness (NAMI) Dane County
63. National Alliance on Mental Illness (NAMI) Wisconsin
64. National Association of Health Education Centers - NAHEC
65. National Association of Social Workers (NASW) - Wisconsin Chapter
66. New Horizons North - Community Support
67. North Country Independent Living
68. Northeastern Wisconsin Area Health Education Center, Inc.
69. Northern Wisconsin Area Health Education Center (NAHEC)
70. Northwest Counseling Services
71. Nova Counseling Services - Oshkosh
72. Pathways to Independence, Waisman Center
73. Perinatal Foundation
74. Planned Parenthood of Wisconsin
75. Racine Friendship Clubhouse
76. Reach Counseling Services - Menasha
77. Regional Employee Assistance Services
78. Representative Alvin Ott
79. Representative Chuck Benedict
80. Representative Donna Seidel
81. Representative Frank Boyle
82. Representative Gary Sherman
83. Representative James Soletski
84. Representative Jason Fields

85. Representative Jeff Smith
86. Representative Mark Pocan
87. Representative Mike Sheridan
88. Representative Robert Turner
89. Representative Sheryl Albers
90. Representative Sondy Pope-Roberts
91. Representative Therese Berceau
92. Rogers Behavioral Health System, Inc.
93. Rogers Memorial Hospital
94. Rosebud & Friends
95. Senator Dave Hansen
96. Senator Jon Erpenbach
97. Senator Judith Robson
98. Senator Kathleen Vinehout
99. Senator Mark Miller
100. Senator Risser
101. Senator Robert Wirch
102. Senator Sheila Harsdorf
103. Senator Tim Carpenter
104. Shorehaven Behavioral Health, Inc.
105. Sixteenth Street Community Health Center
106. Society's Assets
107. SoSiab Care, Inc.
108. Southern Services Center for Independent Living
109. Southwest Wisconsin AHEC
110. Stowell Associates SelectStaff, Inc.
111. Substance Abuse Services Network
112. Survival Coalition of Wisconsin Disability Organizations
113. SWCAP Reproductive Health Care Center
114. Systemic Perspectives
115. Tellurian UCAN, Inc.
116. The Consumer Satisfaction Team
117. The Dane County Mental Health Consortium
118. The Gathering Place
119. The Open Gate
120. The Partners Advocacy
121. The United Community Center
122. The Wisconsin Coalition Against Sexual Assault, Inc. (WCASA)
123. The Wisconsin Pathways to Independence
124. The Wisconsin Prevention Network
125. The Wisconsin Primary Health Care Association (WPHCA)
126. Transitional Living Services
127. Tri-County Council on Domestic Violence & Sexual Assault
128. United Cerebral Palsy of Wisconsin
129. United Way Fox Cities
130. United Way of Greater Milwaukee

131. United Way of Wisconsin
132. University of Wisconsin -Baraboo/Sauk County
133. University of Wisconsin School of Medicine and Public Health
134. University of Wisconsin Stout
135. University of Wisconsin System
136. UW Health
137. UW La Crosse
138. UW Medical School-WI AHEC System, Inc.
139. UW Richland
140. UW Rock County
141. UW Vets for Vets
142. Voices of Hope Consumer Group
143. Waukesha Memorial Hospital -Behavioral Medicine Center
144. Wisconsin Catholic Conference
145. Wisconsin AHEC, Program Office
146. Wisconsin Alcohol and Drug Treatment Providers Association
147. Wisconsin Alcohol, Drug and Disability Association
148. Wisconsin Alliance for Women's Health (WAWH)
149. Wisconsin Association for Perinatal Care (WAPC)
150. Wisconsin Association of Family & Children's Agencies
151. Wisconsin Association of Local Health Departments and Boards (WALHDAB)
152. Wisconsin Association of Local Health Departments and Boards (WALHDAB)
153. Wisconsin Association of Marriage and Family Therapy
154. Wisconsin Association on Alcohol and Other Drug Abuse
155. Wisconsin Chapter, American Academy of Pediatrics (WIAPP)
156. Wisconsin Coalition Against Domestic Violence (WCADV)
157. Wisconsin Coalition of Independent Living Centers
158. Wisconsin Community Action Program Association (WISCAP)
159. Wisconsin Community Services, Inc.
160. Wisconsin Correctional Service
161. Wisconsin Council on Mental Health
162. Wisconsin Department of Veterans Affairs
163. Wisconsin Family Planning and Reproductive Health Association (WFPRHA)
164. Wisconsin Family Ties
165. Wisconsin Federation of Nurses & Health Professionals (WFNHP)
166. Wisconsin Independent Businesses, Inc. (WIB)
167. Wisconsin Interfaith IMPACT
168. Wisconsin Jewish Conference
169. Wisconsin Medical Society
170. Wisconsin Mental Health Association
171. Wisconsin Nurses Association (WNA)
172. Wisconsin Office of Rural Health
173. Wisconsin Psychiatric Association

174. Wisconsin Psychological Association
175. Wisconsin Public Health Association (WPHA)
176. Wisconsin School Psychologists Association, Inc.
177. Wisconsin United for Mental Health (WUMH)
178. Wisconsin Women's Health Foundation, Inc. (WWHF)
179. Write Resources, LLC

Wisconsin Jewish Conference

MJC Milwaukee Jewish Council for Community Relations

Testimony before the Senate Committee on Health, Human Services, Insurance, and Job Creation
SB 375
January 17, 2008

Milwaukee Jewish Council for Community Relations: Barbara Beckert, Assistant Director
Jewish Family Services: Judy Strauss, Vice President Clinical & Counseling Services
Wisconsin Jewish Conference: Michael Blumenfeld, Executive Director

Thank you for the opportunity to testify today on behalf of our respective agencies: the Milwaukee Jewish Council for Community Relations, which represents 28 local Jewish organizations, agencies and synagogues; Jewish Family Services, which provides comprehensive social services for Milwaukee area individuals and families; and the Wisconsin Jewish Conference, which represents 17 Jewish communities throughout Wisconsin.

Jewish tradition teaches us that providing health care is not just an obligation for the patient and the doctor but for society as well. It is for this reason that Maimonides, a revered Jewish scholar, listed health care first on his list of the ten most important communal services that a city had to offer to its residents. Our tradition recognizes that good health encompasses not only the physical dimension, but also the mental, and that the obligation to maintain mental health is an important component of the broader obligation to preserve health.

Mental illness affects one in five Americans, adults and children alike. Coverage for mental health services is very limited under most private insurance plans and government programs and far more restrictive than the coverage provided for treatment of other illnesses. These inequities in the insurance statutes prevent many individuals with mental illness and substance abuse disorders from receiving medically necessary treatment. The long-term consequences of these untreated disorders are costly, in both human and fiscal terms.

Jewish agencies including Jewish Family Services (JFS), the Jewish Home and Care Center, and Jewish Social Services of Madison play a significant role in the delivery of mental health services. Our agencies are regularly contacted by individuals and families in urgent need of mental health services who have little or no insurance coverage. The majority are employed and many have insurance, but their coverage for mental health services is extremely limited or completely lacking. There is nowhere to refer these individuals who are so desperately in need of help but lack the necessary insurance coverage and financial resources. In an attempt to provide an ethical and caring response to this human suffering, JFS is one of the only agencies in the community to provide mental health services on a sliding scale, and the demand for these services has become overwhelming. As a result, our mental health services run at a significant loss because of the large number of clients who do not have coverage or have very limited coverage, and we are struggling to continue this commitment.

We strongly support enactment of legislation to reduce financial barriers to treatment, including creating parity in the treatment of physical and mental illnesses under private health insurance plans and government programs. Wisconsin is one of only twelve states which does not have mental health parity. Now is the time to improve access to mental health services by implementing comprehensive mental

health/ substance abuse parity. Therefore, we urge you to act now by unanimously recommending SB 375 for passage before the full Senate.

According to Mental Health America, thirty-eight states now have some type of mental health parity. PriceWaterhouseCoopers, LLP, and others have found that these laws have not led to significant increases in costs or in the uninsured and often premiums have decreased as a result. Wisconsin is one of only 12 states which have not addressed this essential health care issue. Mental illness affects one in four families. Although treatment works, many people do not get the help they need because of unequal coverage for mental illness and substance abuse disorders. The current Wisconsin mandatory minimums ($7000 per year for inpatient and $2000 for outpatient) have not changed in over 20 years. Weekly visits with a mental health professional will easily use up that amount well before the end of the year. And, inpatient treatment costs over $1500 a day in Wisconsin.

Businesses that provide insurance coverage of mental illnesses have also found an unexpected benefit in reduced sick leave for physical ailments. Increased productivity and fewer sick days have resulted in a net positive for these businesses. Parity makes good economic sense. It's time for a change.

Comprehensive parity will ensure that coverage for medically necessary treatment of all mental health and substance abuse disorders is no more restrictive than the coverage for other medical conditions. Please pass SB 375 now to ensure that Wisconsin residents have improved access to this essential medical care and to help end discrimination against people experiencing mental health concerns.

Thank you for your time and consideration.

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The Mental Health Divide:

MENDING THE SPLIT BETWEEN MIND AND BODY

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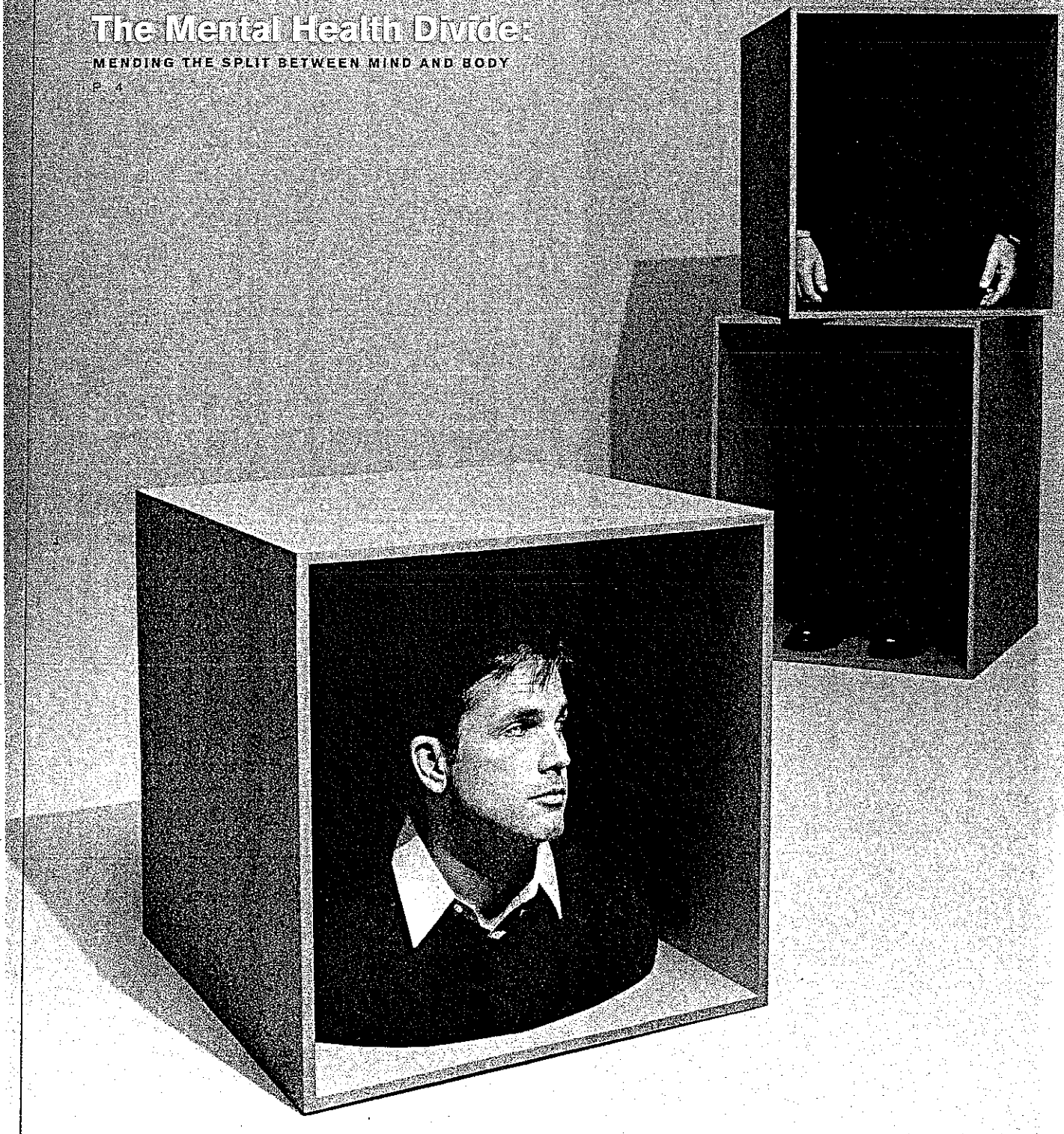

Letter From Milliman CEO Pat Grannan

Milliman is celebrating its 60th anniversary this year. It's humbling to look back over the years and consider the contributions from all of the professionals who got us to where we are today.

No single quality can be credited for 60 years of excellence, but if I had to pick one that is manifest in virtually everything we say and do, it would be independence. Since the firm's founding, Milliman's professionals have shared a commitment to independent thinking and objective consulting.

This is evidenced in the slate of articles in this latest issue of *Insight*. Our cover story, "The Mental Health Divide: Mending the Split Between Mind and Body," by Steve Melek, has a distinct point of view as it makes the case for rethinking the delivery of mental healthcare in the U.S. If I were to poll our consultants, I'm sure there would be some who believe another approach to mental healthcare is in order; however, I doubt that any would dispute that Steve's work on mental healthcare parity is of the highest caliber and that his story ought to be told. That is the beauty of a truly independent culture: We don't all have to agree in order to see the value of each other's perspectives.

There is a similar example of independence in the article by Ginny Boggs and Suzanne Smith, about the massive changes in 403(b) plans, a popular type of retirement plan for not-for-profit organizations. The authors raise some questions about the fees built into annuity-type products, even though our life insurance practice works extensively with clients who provide annuity products.

While I am aware of the possibility of a negative reaction from annuity providers, I would be more concerned if we allowed a conflict of interest to take root, interfering with our consultants' ability to provide the full benefit of their thinking and expertise to their clients. If we continue to provide that type of consulting to our clients, I have no doubt that, 60 years from now, Milliman will have cause for further celebration.

Pat Grannan

PATRICK GRANNAN

Milliman Chief Executive Officer

THE MENTAL HEALTH DIVIDE:

MENDING THE SPLIT BETWEEN MIND AND BODY

BY STEVE MELTER, LISW-S, M.A.

"OUR PROBLEMS ARE MAN-MADE, THEREFORE THEY MAY BE SOLVED BY MAN. AND MAN CAN BE AS BIG AS HE WANTS. NO PROBLEM OF HUMAN DESTINY IS BEYOND HUMAN BEINGS."

—JOHN F. KENNEDY

Depression and other major mental and substance-related illnesses can have a paralyzing effect on an otherwise healthy person. As hope and optimism fade, so does the urge to stay healthy. Depression can compound the severity of a problem for people with chronic physical illnesses, who can cost two to three times as much to treat if they are depressed. And depression itself can lead to poor health, as it often leaves people unmotivated and causes high-risk patients to ignore prevention or necessary treatments, opening the door to chronic and acute illness.

The symbiotic relationship between behavioral health and physical health is often not recognized. Instead, the behavioral healthcare environment that has emerged in the last two decades has largely ignored the interconnectedness between mind and body. It doesn't have to be this way. Indeed, a dramatic transformation for the healthcare industry is ahead as a handful of insurers and employers are beginning to identify the opportunities and economic incentives related to (1) providing benefits for behavioral illnesses on par with physical illnesses, and (2) integrating medical and behavioral healthcare for insured populations.

The split between mind and body in healthcare has been a problem for years, but has been convenient to ignore because, over the last two decades, costs for the care of behavioral disorders fell remarkably as managed-care business practices streamlined the behavioral healthcare industry. More recently, evidence has emerged about the adverse long-term medical effects of untreated behavioral disorders. These two dynamics now combine to suggest that parity in mental and physical health coverage—essentially, financing both on the same basis—would result in a very small added healthcare cost at worst, and quite possibly, a net reduction in total costs.

The first part of this mental healthcare transformation is embodied by the House behavioral health parity bill, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, and the Senate behavioral health parity bill, the Mental Health Parity Act of 2007. To appreciate the impact of these bills and the benefits of behavioral healthcare parity, it is useful to look back at how the current behavioral healthcare situation developed.

Behavioral Healthcare Carve-Outs: 170 Million Served

The managed-care approach to behavioral healthcare was not built in a day. In the 1980s, before managed behavioral

healthcare existed, insurance cost trends for mental health and substance-related disorders were much higher than for mainstream physical healthcare.

Inpatient treatment might have lasted weeks, if not months; recurrence rates were very high, especially with chemical dependency; and behavioral healthcare delivery was criticized as being subjective. At that time, 10 different behavioral professionals might offer 10 different remedies for depression, as compared with treatment for a common physical ailment such as appendicitis, which is almost always fairly straightforward. There was more mystique around behavioral healthcare than around medical care in general.

Early cost-reduction attempts by health insurers called for limits on covered services because insurers couldn't control how behavioral healthcare was administered. For chemical dependency, a common limit was a lifetime cap of only two stays in an addiction recovery facility—a simple way to address high recurrence rates.

With managed care, payers used two tools in the traditional medical sector: utilization management and bargaining directly with providers to lower their prices via network contracts. But the "how to" of applying these techniques to behavioral healthcare treatment was initially unclear.

Some behavioral healthcare professionals, often clinicians, saw a business opportunity. Organizations that later became known as managed behavioral healthcare organizations (MBHOs) began sprouting up to "carve out" the behavioral healthcare benefits from health plans. Typical health plans developed their own managed-care approach to physical healthcare, but rarely had the expertise to do so for behavioral healthcare. The MBHOs filled this void. These MBHOs would contract with health plans to receive a flat dollar amount per insured member per month (capitation) and manage the behavioral service risk within this budget.

This approach delegated the financial risk of insuring behavioral healthcare to the behavioral specialty companies. It became the MBHO's responsibility to build the specialty behavioral network, manage the behavioral healthcare services, pay the providers, provide customer service, and generally do everything a health plan does, but with an exclusive focus on behavioral healthcare benefits.

MBHOs grew rapidly from the mid-1980s to the late 1990s, when they served 170 million people insured by managed-care plans. These specialty behavioral healthcare organizations had financial incentives to reduce costs through utilization management and aggressive provider contracting; they even steered certain patients back into the physical healthcare system. Through effective specialty behavioral healthcare management, cost trends dropped for several years, which was the initial goal of health insurance payers. But this trend had other adverse impacts.

Adverse Effects of the Growth of MBHOs

The growth of this carve-out sector was not without its unintended consequences, not the least of which was that it truly separated the mind from the body in healthcare delivery. Because the carve-out sector is typically completely separate from the rest of the medical industry, treatment of the mind takes place in isolation from treatment of the rest of the patient. The same disconnect applies to physical health, and even problems with the brain are often treated as part of physical healthcare with little consideration of their effect on behavioral health.

This divided system misaligns patients' incentives for healthy outcomes and the overall well-being of patients suffering from behavioral disorders. Although the behavioral healthcare sector is much more effective at treating and curing behavioral disorders, insurance plans require the patient to pay more to obtain treatment within the specialty behavioral healthcare sector. And because insurance plans pay carve-outs a flat monthly fee per insured member regardless of how many patients they treat, carve-outs make more money if patients instead seek treatment within the traditional medical sector, where they typically obtain prescription medication for their disorders. Many of these medications have great promise yet turn out to be ineffectively used.

The outcomes are horrible. Only eight out of 100 patients suffering from behavioral disorders receive minimally effective treatment in the dual system that exists today. Sixty of these 100 patients receive no treatment for their disorders. And because behavioral disorders very often manifest through pain and other physical symptoms, patients often seek treatments for such physical ailments in general medical settings, without effective treatment for the root cause. In general medical settings, the percentage of patients that receive minimally effective treatment for their behavioral disorders is just 13%.[1]

The impact of behavioral illness goes beyond health insurance costs. A depressed person completes one or two fewer hours' worth of work per day than someone who is not depressed, a phenomenon known as "presenteeism." Sick days, disabilities, and on-the-job accidents also increase for employees with behavioral disorders.

Affordable Parity

Fifteen years ago, the estimated cost of mandating behavioral healthcare parity would have swallowed the profit margins of most health insurance plans. But the trend in specialty behavioral healthcare has been one of dramatically falling costs, and recent estimates of parity costs are considerably lower today than those of a dozen years ago, when the Clinton administration pushed reform efforts.

The direct effects of parity on the cost of healthcare plans come in two forms. First, cost sharing for behavioral health

1 P.S. Wang, M. Lane, M. Olfson, H.A. Pincus, K.B. Wells, R.C. Kessler, "Twelve-month Use of Mental Health Services in the U.S.: Results From the National Co-morbidity Survey Replication," *Archives of General Psychiatry*, 2005.

Status Check: Mental Health

- The number of Americans with diagnosable behavioral disorders has stayed fairly stable in recent years, at about 22%. But of 100 such patients, only 10 seek treatment in the specialty behavioral healthcare sector. Only four to five of these 10 receive minimally effective treatment that leads to recovery.[2]
- Of the remaining 90 patients, 60 receive no specific treatment for their behavioral disorders, and many are not at all aware of the underlying behavioral disorder that is contributing to their reduced health status. The remaining 30 patients seek treatment from their primary-care physicians. Of those 30, only four get minimally effective, evidence-based treatment that leads to recovery.[3]
- Of patients diagnosed with depression, some 80% initially seek treatment for pain. Depression can manifest itself through physical symptoms like headaches, stomachaches, back pain, and joint pain.
- A patient with diabetes and depression costs twice as much to treat on average as a diabetic who is not depressed. Of that extra cost, 80% is for treating the physical ailment that is exacerbated by the depression. With some chronic medical illnesses, a depressed patient can cost three times as much as a non-depressed patient.[4]
- In the primary-care sector, the typical treatment for a patient diagnosed with mental health disorders is a psychotropic drug prescription, often with very little education about what to expect from the drugs and how long before they become effective. Many antidepressants require two months of daily doses to become effective, and six months of daily doses to fully achieve remission of the mental disorder. Most come with side effects that make the patients feel worse long before they feel better. One-third of patients don't even finish the first month of their prescriptions.
- Most behavioral disorders are curable if treated properly with professional therapy, drug treatments, or a combination of both, yet only eight out of 100 patients receive minimally effective treatment in the dual system that exists today.

FIGURE 1. TYPICAL COST INEQUITY IN MENTAL HEALTHCARE

TYPE OF CARE	Surgery for appendicitis	Mental health treatment (inpatient)
DEDUCTIBLE	$250	$2,000
COPAY	For primary-care doctor: $10	For mental health professional: $25–$50
INSURANCE COVERAGE	90% of surgery costs, up to $1,000 out-of-pocket limit	70% of treatment costs, up to $5,000 out-of-pocket limit

services would be made equal to the cost-sharing provisions for physical care, which would raise insured healthcare costs. Second, the benefit limits that most plans apply to mental health conditions—like annual caps on therapy sessions or hospital stays—would be removed, also bringing the potential to raise insured healthcare costs.

The insurance industry had feared that removing these annual caps would provide a blank check for beneficiaries to over-use behavioral services. But the behavioral healthcare industry has transformed so dramatically over the last two decades that this "Chicken Little" prediction is highly unlikely.

For example, many plans have annual inpatient day limits, such as 60 days per year, on hospital stays for behavioral disorders. But admissions rarely last longer than 10 days. To break the limit, patients would have to be readmitted several times in the same year, and have relatively long inpatient stays. This may be common among pop stars or fugitives, but for the average (managed) behavioral health patient is very unlikely.

Higher insured out-of-pocket payments and policy limits have created great obstacles for people who actually need the specialty behavioral care (see Figure 1). These limits were put in place to purposely raise the cost to patients and prevent the runaway utilization of services at a time when excessive utilization was a real problem. But cases of runaway demand and high utilization are rare when these benefits are managed.